STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR
BOARD OF VOCATIONAL NURSING & PSYCHIATRIC TECHNICIANS
2535 Capitol Oaks Drive, Suite 205, Sacramento, CA 95833-2945
Phone (916) 263-7800 Fax (916) 263-7866 | Web www.bvnpt.ca.gov

CLINICAL FACILITY APPROVAL APPLICATION

FOR BOARD USE ONLY

Date Approved: _____

Approved By: _____

SCHOOL NAME: _____VN or PT (Circle one)

SUBMIT FORM IN DUPLICATE PRIOR TO USE OF FACILITY. This information is required under Business and Professions Code, Division 2. **All information requested is mandatory**. Failure to provide this information will result in the application being rejected as incomplete.

THIS SECTION TO BE COMPLETED BY THE FACILITY (ITEMS 1-11), REVIEWED (ITEMS 12-15), SIGNED, THEN RETURNED TO THE SCHOOL DIRECTOR REQUESTING AFFILIATION.

1. NAME OF FACILITY:

2. ADDRESS:_____

CITY: _____**STATE:**_____**ZIP**_____

TELEPHONE #: _____ **FAX #:** _____
(Area Code) (Area Code)

EMAIL ADDRESS: _____

3. NAME OF ADMINISTRATOR:

4. NAME OF DIRECTOR:

5. NAME OF FACILITY STUDENT PLACEMENT COORDINATOR:

6. TYPE OF FACILITY:

7. LICENSE STATUS (check one):
❑ Licensed ❑Certified

8. CLIENT POPULATION:
❑ Adults ❑ Peds
❑ Adults/Peds ❑ Geriatrics

9. AVERAGE DAILY CENSUS FOR FACILITY:

10. INDICATE THE UNITS/SERVICES (OB, Med Surg, Peds, etc.) AVAILABLE TO THIS SCHOOL, THE AVERAGE DAILY CENSUS FOR EACH, AND THE MAXIMUM NUMBER OF STUDENTS FROM THIS SCHOOL THAT EACH UNIT CAN ACCOMMODATE.

UNITS/SERVICES						
Average daily census for unit/services						
# of students possible per unit/services						

11. PLEASE ANSWER THE FOLLOWING QUESTIONS:

A. Were the students' clinical objectives given to you for review? ❑ Yes ❑ No
B. Are the students' clinical objectives achievable in your agency? ❑ Yes ❑ No
C. What is the instructor/student ratio permitted by your facility? Ratio is ____ instructors to ____ students
D. Will the instructor(s) have an orientation to your facility? ❑ Yes ❑ No
E. Is the instructor free to make assignments which correlate with current theory classes, including medications, treatments, use of equipment and charting? ❑ Yes ❑ No
F. Is the instructor free to move students to areas where immediate, pertinent learning is available (even with short notice)? ❑ Yes ❑ No
G. Is adequate space available for classes and conferences? ❑ Yes ❑ No
H. Is this space available for uninterrupted use by students and faculty? ❑ Yes ❑ No
If not, what other arrangements have been made?

***See page 2 for Facility Signature.**

THIS SECTION TO BE COMPLETED BY THE SCHOOL DIRECTOR (ITEMS 12-15).

12. THE FOLLOWING INFORMATION MUST BE COMPLETED FOR EACH LEVEL OF STUDENT.
IF THE CLINICAL EXPERIENCE IS A SATELLITE SITE, CHECK THIS BOX ❑

- **LENGTH OF ROTATION PER STUDENT _____.**

A. Level of Student				
B. Starting Date				
C. Unit/Services				
D. Number of Students				
E. Days of Week				
F. Time of Day				
G. Total Hours per Week				
H. Pre-Conference Days & Times				
I. Post-Conference Days &Times				
J. Instructor on Site Days **List Days & Times Times**				

13. ❑ ATTACH CLINICAL OBJECTIVES FOR EACH STUDENT LEVEL
❑ ATTACH PLAN FOR FACULTY ORIENTATION TO FACILITY

14. PLEASE ANSWER THE FOLLOWING QUESTIONS. DID YOU DISCUSS WITH THE FACILITY:

A. Specific nursing care and procedures which the objectives require?	**❑ Yes**	**❑ No**
B. Student learning needs and experiences?	**❑ Yes**	**❑ No**
C. Students' course description and clinical objectives?	**❑ Yes**	**❑ No**
D. The scheduling of conference rooms?	**❑ Yes**	**❑ No**
E. The facility's documentation and charting methodology?	**❑ Yes**	**❑ No**
F. The facility's policies and procedures relative to student placement?	**❑ Yes**	**❑ No**
G. The location of emergency and non-emergency equipment?	**❑ Yes**	**❑ No**
H. Emergency and non-emergency procedures?	**❑ Yes**	**❑ No**

15. I HEREBY CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE AND CORRECT.

School Director's Signature:_____ Date:_____

School Director's Printed Name: _____Date:_____

This signature confirms that I have reviewed the contents of this form.

FACILITY Director's Signature: _____DATE: _____

FOR BOARD USE ONLY

Board Action: Spoke with_____ ❑ Approved ❑ Denied

Comments:

Board Consultant's Signature: Date: